		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0023382

Facility Name: Eden Village Care Center

Address: 400 South Station Road (Number) Glen Carbon (City) 62034 (Zip Code)

County: Madison

Telephone Number: (618) 288-5016 **Fax #** (618) 288-0206

IDPA ID Number: 37-1032262001

Date of Initial License for Current Owners: May 14, 1979

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code	501©(3)	[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Scheffel & Company, P.C. **Telephone Number:** (618) 656-1206

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Dennis Ulrich, Certified Public Accountant

(Firm Name & Address) Scheffel & Company, P.C.
143 North Kansas St., Edwardsville, IL 62025

(Telephone) (618) 656-1206 Fax # (618) 656-3536

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	132	Skilled (SNF)	132	48,180	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	132	TOTALS	132	48,180	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	420	1,523	1,427	3,370	8
9	SNF/PED					9
10	ICF	15,497	26,121		41,618	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,917	27,644	1,427	44,988	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 93.37%

D. How many bed-hold days during this year were paid by Public Aid?
119 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Outpatient Therapy

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/14/79

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/14/79 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 1,427

Medicare Intermediary Mutual of Omaha, P.O. Box 1602, Omaha, NE 68101

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	226,647	22,981	7,302	256,930		256,930		256,930			1
2	Food Purchase		175,998		175,998		175,998	(8,880)	167,118			2
3	Housekeeping	112,253	20,112	135	132,500		132,500		132,500			3
4	Laundry	95,277	13,197	7,641	116,115		116,115		116,115			4
5	Heat and Other Utilities			150,753	150,753		150,753		150,753			5
6	Maintenance	63,988	13,200	58,472	135,660		135,660		135,660			6
7	Other (specify):*											7
8	**TOTAL General Services**	498,165	245,488	224,303	967,956		967,956	(8,880)	959,076			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,489,480	119,782	217,484	1,826,746		1,826,746		1,826,746			10
10a	Therapy	171,808	1,689	47,344	220,841		220,841		220,841			10a
11	Activities	54,156	5,359	1,625	61,140		61,140		61,140			11
12	Social Services	90,698	200	1,767	92,665		92,665		92,665			12
13	Nurse Aide Training			14,286	14,286		14,286		14,286			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,806,142	127,030	282,506	2,215,678		2,215,678		2,215,678			16
	C. General Administration											
17	Administrative	107,127			107,127		107,127		107,127			17
18	Directors Fees											18
19	Professional Services			33,460	33,460		33,460		33,460			19
20	Dues, Fees, Subscriptions & Promotions			79,164	79,164		79,164	(50,221)	28,943			20
21	Clerical & General Office Expenses	118,326	26,515	86,749	231,590		231,590		231,590			21
22	Employee Benefits & Payroll Taxes			402,704	402,704		402,704		402,704			22
23	Inservice Training & Education			784	784		784		784			23
24	Travel and Seminar			3,460	3,460		3,460		3,460			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			38,525	38,525		38,525		38,525			26
27	Other (specify):*	13,671		24,263	37,934		37,934	(37,934)				27
28	**TOTAL General Administration**	239,124	26,515	669,109	934,748		934,748	(88,155)	846,593			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,543,431	399,033	1,175,918	4,118,382		4,118,382	(97,035)	4,021,347			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Eden Village Care Center #0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			274,850	274,850		274,850		274,850			30
31	Amortization of Pre-Op. & Org.			2,025	2,025		2,025		2,025			31
32	Interest			129,996	129,996		129,996	(18,840)	111,156			32
33	Real Estate Taxes			9,360	9,360		9,360	(9,360)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			12,224	12,224		12,224		12,224			35
36	Other (specify):*											36
37	**TOTAL Ownership**			428,455	428,455		428,455	(28,200)	400,255			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	51,723		40,572	92,295		92,295		92,295			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			73,936	73,936		73,936		73,936			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	51,723		114,508	166,231		166,231		166,231			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,595,154	399,033	1,718,881	4,713,068		4,713,068	(125,235)	4,587,833			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,866)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(18,840)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,014)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(24,263)	27		24
25	Fund Raising, Advertising and Promotional	(42,349)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,872)	20		28
29	Other-Attach Schedule See Attached	(23,031)	27,33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (125,235)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (125,235)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Eden Village Care Center

ID# 0023382

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Real Estate Taxes	$ (9,360)	33	1
2	Marketing Salaries	(13,671)	27	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(23,031)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Eden Village Care Center # 0023382 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,880)	0	0	0	0	0	0	0	0	0	0	(8,880)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,880)	0	0	0	0	0	0	0	0	0	0	(8,880)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(50,221)	0	0	0	0	0	0	0	0	0	0	(50,221)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(37,934)	0	0	0	0	0	0	0	0	0	0	(37,934)	27
28	**TOTAL General Administration**	(88,155)	0	0	0	0	0	0	0	0	0	0	(88,155)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(97,035)	0	0	0	0	0	0	0	0	0	0	(97,035)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Eden Village Care Center **#** 0023382 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(18,840)	0	0	0	0	0	0	0	0	0	0	(18,840)	32
33	Real Estate Taxes	(9,360)	0	0	0	0	0	0	0	0	0	0	(9,360)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(28,200)	0	0	0	0	0	0	0	0	0	0	(28,200)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(125,235)	0	0	0	0	0	0	0	0	0	0	(125,235)	45

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Child Care Center	Glen Carbon	Child Care

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Village of Glen Carbon		X	Construction & Equipment		12/31/96	$ 2,300,000	$ 1,850,000	10/01/11	5.1 - 5.8%	$ 106,056	1
2	Deferred Compensation Plan		X	Deferred Compensation							23,940	2
3												3
4	less: Interest Income										(18,840)	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 2,300,000	$ 1,850,000			$ 111,156	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,300,000	$ 1,850,000			$ 111,156	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	0	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	9,360	2
3. Under or (over) accrual (line 2 minus line 1).	$	9,360	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	9,360	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	991	8
	1996	991	9
	1997	5,601	10
	1998	19,392	11
	1999	26,526	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,240 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Eden Retirement Center, Independent Living Facility, 79 Apartments, 32 Duplex units
Eden Childcare Center, Child Daycare Facility

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Land			$ 166,295	1
2					2
3	TOTALS			$ 166,295	3

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	132		1979	1979	$ 2,008,520	$ 65,667	30	$ 65,667	$	$ 1,451,240	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Parking Lot			1981	12,145		15			12,145	9
10	Landscaping			1993	809	81	10	81		600	10
11	Flower Bed Irrigation System			1997	2,450	163	15	163		517	11
12	Parking Lot			1979	62,453		10			62,453	12
13	Alarm System			1979	1,193		10			1,193	13
14	Additions			1985	28,766	973	30	973		14,652	14
15	Roof			1989	21,453	1,073	20	1,073		12,336	15
16	Office Addition			1990	34,575	1,153	30	1,153		11,814	16
17	Interior Office Walls			1991	3,102	124	25	124		1,230	17
18	Gas Pipe			1991	5,850	234	25	234		2,321	18
19	Parking Lot			1991	8,447	563	15	563		5,162	19
20	Floor-Kitchen			1991	3,046	152	20	152		1,408	20
21	Blocks-Parking Lot			1991	391	26	15	26		260	21
22	Building Remodeling			1991	104,840	4,194	25	4,194		33,899	22
23	Paved Entrance Drive			1992	1,890	126	15	126		1,082	23
24	Gutters			1993	293	15	20	15		109	24
25	Fence			1993	700	47	15	47		346	25
26	Patio Roof			1993	3,285	164	20	164		1,218	26
27	Roof			1993	10,956	548	20	548		3,926	27
28	Signs			1993	6,956	580	12	580		4,058	28
29	Remodel Hall I			1993	23,174	927	25	927		6,643	29
30	Remodel Hall III			1993	20,060	802	25	802		5,616	30
31	Walkpads			1993	1,085	54	20	54		429	31
32	Driveway Seal			1993	950	48	20	48		337	32
33	Parking Lot			1994	3,188	159	20	159		1,023	33
34	Remodel Hall III			1994	10,620	425	25	425		2,868	34
35				1994	2,896	193	15	193		1,287	35
36	TOTAL (lines 4 thru 35)				$ 2,384,093	$ 78,491		$ 78,491	$	$ 1,640,172	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodel Hall V			1994	8,141	326	25	326		2,198	9
10	Improvements			1994	650	43	15	43		267	10
11	Improvements			1994	138	9	15	9		56	11
12	Crash Rails			1994	3,070	205	15	205		1,228	12
13	Improvements			1995	2,841	142	20	142		722	13
14	Rubber Roof Installation			1995	23,522	1,176	20	1,176		6,272	14
15	Rubber Roof Installation			1995	23,522	1,176	20	1,176		5,978	15
16	Shower Room Improvements			1995	6,285	314	20	314		1,571	16
17	Improvements			1995	2,360	118	20	118		679	17
18	Improvements Room 501			1995	1,800	90	20	90		510	18
19	Improvements Rooms 403 405 407			1995	5,400	270	20	270		1,530	19
20	Improvements Rooms 400 401			1995	4,035	202	20	202		1,144	20
21	Improvements Rooms 409 411 413			1995	5,400	270	20	270		1,485	21
22	Improvements Rooms 408 410 412			1995	5,754	288	20	288		1,559	22
23	Improvements Rooms 402 404 406			1995	5,594	280	20	280		1,492	23
24	Design & Engineering Cost			1995	4,410	221	20	221		1,268	24
25	Improvements			1996	1,867	93	20	93		466	25
26	Crash Rails			1996	2,829	189	15	189		912	26
27	Remodel Rooms 509 511 513			1996	7,080	354	20	354		1,682	27
28	Remodel Rooms 503 505 507			1996	7,080	354	20	354		1,652	28
29	Install Phone Jacks			1996	210	21	10	21		98	29
30	Remodel Rooms 502 504 506			1996	7,080	354	20	354		1,623	30
31	Install Phone Jacks			1996	210	21	10	21		94	31
32	Remodel Rooms 508 510 512			1996	7,080	354	20	354		1,564	32
33	Remodel Rooms 209 211 213			1996	7,080	354	20	354		1,534	33
34	Remodel Rooms 203 205 207			1996	7,080	354	20	354		1,504	34
35	Remodel Rooms 200 202 204			1996	7,080	354	20	354		1,475	35
36	TOTAL (lines 4 thru 35)				$ 157,598	$ 7,932		$ 7,932	$	$ 40,563	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Remodel Rooms 206 208 210			1996	7,080	354	20	354		1,416	9
10	Remodel Room 212			1996	2,360	118	20	118		472	10
11	Roof Repair			1997	3,550	178	20	178		592	11
12	Prep and Paint Walls			1994	13,333	1,332	10	1,332		8,443	12
13	Vinyl Fence			1998	3,731	249	15	249		726	13
14	Parking Lot Asphalt			1998	18,949	1,895	10	1,895		4,422	14
15	Expansion Carpet & Wallcovering			1998	14,587	2,917	5	2,917		8,509	15
16	Carpet-Admin/Chapel			1998	19,121	3,824	5	3,824		10,835	16
17	Wall Covering-Lobby			1998	876	88	5	88		249	17
18	Walk off Pad			1998	1,514	101	15	101		286	18
19	Wall Covering-Therapy			1998	1,603	160	5	160		454	19
20	Wall Coverings-7 Rooms			1998	17,500	1,750	5	1,750		4,229	20
21	Expansion Construction-Admin & Patient Rooms			1998	895,205	22,380	30	22,380		65,275	21
22	Expansion Construction-Therapy Center			1998	522,203	13,055	30	13,055		34,813	22
23	Construction-Eng. & Archit. Fees			1998	126,455	4,215	30	4,215		12,294	23
24	Roof Repair			1998	7,452	745	10	745		1,987	24
25	Design Cost			1999	734	24	30	24		46	25
26	Corner Protectors			1999	1,701	113	15	113		189	26
27	17 Fire/Smoke Dampers			1999	22,104	1,474	15	1,474		2,948	27
28	Electrical Circuit Installation			1999	447	30	15	30		45	28
29	Wallcoverings: Halls 1 & 2, Nurses Station			1999	4,412	441	10	441		736	29
30	Alarm System Repair			1999	1,840	123	15	123		195	30
31	Sprinkler System Improv.			1999	3,135	209	15	209		331	31
32	Engineering Consulting			1999	899	60	15	60		75	32
33	Wallcovering: Halls 3 &4, Main Hall			1999	10,329	1,033	10	1,033		2,066	33
34	Crash Rail			1999	25,475	1,698	15	1,698		3,396	34
35	Wallcovering: Dining Room, Alzh. Dining Area			1999	9,925	993	10	993		1,700	35
36	TOTAL (lines 4 thru 35)				$ 1,736,520	$ 59,559		$ 59,559	$	$ 166,729	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Alzheimers Construction			1999	504,922	12,623	40	12,623		19,986	9
10	100' Vinyl Fence			1999	1,383	92	15	92		107	10
11	Signage Program			1999	20,523	1,368	10	1,368		2,508	11
12	Courtyard Landscaping			1999	8,900	890	10	890		1,261	12
13	Pond Sidewalk			1999	3,485	232	15	232		329	13
14	Monumental Plaque			1999	148	14	10	14		28	14
15	Custom Door, Frame, Hinges			2000	555	51	10	51		51	15
16	Final CC Renovation Payment			2000	11,000	206	40	206		206	16
17	Carpet - Service hall			2000	2,444	0	5	0		0	17
18	Chair Rails			2000	5,843	0	10	0		0	18
19	Wallpaper & Flooring, Activity Room			2000	1,537	51	5	51		51	19
20	Linoleum, Activity Room			2000	5,523	184	5	184		184	20
21	Sidewalk			2000	4,235	35	20	35		35	21
22	Fully Depreciated Parking Lot			2000	(12,145)	0	15	0		(12,145)	22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 558,353	$ 15,746		$ 15,746	$ 0	$ 12,601	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,045,825	$ 118,582	$ 118,582	$ 0		$ 476,023	37
38	Current Year Purchases	66,073	4,819	4,819	0		4,819	38
39	Fully Depreciated Assets	383,673			0		383,673	39
40	Asset Dispositions	(123,517)	(10,279)	(10,279)	0		(113,580)	40
41	TOTALS	$ 1,372,054	$ 113,122	$ 113,122	$ 0		$ 750,935	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Business	1990 Van	1990	$ 40,188	$ 0	$ 0	$ 0	5	$ 40,188	42
43							0			43
44							0			44
45							0			45
46	TOTALS			$ 40,188	$ 0	$ 0	$ 0		$ 40,188	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 6,415,101	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 274,850	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 274,850	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 0	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,651,188	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 12,224 Description: IV Pumps, Nebulizer, Wheel Chairs, Suction Pumps, Oxygen Cart
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 111

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 44

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$ 343	$ 13,693	$	$ 14,036
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		250		250
9	TOTALS	$ 343	$ 13,943	$	$ 14,286
10	SUM OF line 9, col. 1 and 2 (e)	$ 14,286			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39	hrs	51,724					51,724	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				40,572		40,572	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 51,724		$	$ 40,572		$ 92,296	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 64,613	$	1
2	Cash-Patient Deposits	6,441		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	532,192		3
4	Supply Inventory (priced at Cost)	17,228		4
5	Short-Term Investments	640,619		5
6	Prepaid Insurance	16,368		6
7	Other Prepaid Expenses	3,440		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Interest Receivable	5,502		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,286,403	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	327,356		11
12	Long-Term Investments			12
13	Land	273,478		13
14	Buildings, at Historical Cost	10,263,839		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,891,762		16
17	Accumulated Depreciation (book methods)	(5,495,218)		17
18	Deferred Charges	16,483		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,277,700	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,564,103	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 189,187	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	6,441		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	116,861		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,947		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	12,512		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Prelease Deposits	80,059		36
37	Other Accrued Expenses	105,851		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 531,858	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	297,584		40
41	Bonds Payable	1,850,000		41
42	Deferred Compensation	354,424		42
	Other Long-Term Liabilities(specify):			
43	Deferred Entrance Fees	2,217,079		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,719,087	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,250,945	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,313,158	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,564,103	$	48

***(See instructions.)**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,130,951	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,130,951	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(41,054)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Eden Retirement Center**	223,261	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 182,207	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,313,158	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,651,143	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,651,143	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions	2,031	24
25	Interest and Other Investment Income***	18,840	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 20,871	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,672,014	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	967,956	31
32	Health Care	2,215,678	32
33	General Administration	934,748	33
	B. Capital Expense		
34	Ownership	428,455	34
	C. Ancillary Expense		
35	Special Cost Centers	92,295	35
36	Provider Participation Fee	73,936	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,713,068	40
41	**Income before Income Taxes (line 30 minus line 40)****	(41,054)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (41,054)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,869	1,975	$ 45,152	$ 22.86	1
2	Assistant Director of Nursing	1,869	1,975	44,655	22.61	2
3	Registered Nurses	8,172	9,460	158,519	16.76	3
4	Licensed Practical Nurses	28,088	30,623	461,567	15.07	4
5	Nurse Aides & Orderlies	83,695	91,450	740,109	8.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	11,232	12,667	223,532	17.65	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,011	2,111	21,137	10.01	9
10	Activity Assistants	4,493	4,739	33,019	6.97	10
11	Social Service Workers	6,161	6,641	90,698	13.66	11
12	Dietician					12
13	Food Service Supervisor	3,238	3,398	33,851	9.96	13
14	Head Cook	8,863	9,404	79,916	8.50	14
15	Cook Helpers/Assistants	9,557	9,909	64,818	6.54	15
16	Dishwashers	6,810	7,064	48,063	6.80	16
17	Maintenance Workers	7,336	7,831	63,986	8.17	17
18	Housekeepers	17,123	17,874	112,253	6.28	18
19	Laundry	10,790	11,800	95,278	8.07	19
20	Administrator	1,869	1,975	49,469	25.05	20
21	Assistant Administrator					21
22	Other Administrative	3,210	3,422	57,658	16.85	22
23	Office Manager	1,234	1,386	20,768	14.98	23
24	Clerical	8,461	9,473	79,570	8.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,448	5,654	39,478	6.98	31
32	Other Health Care(specify)					32
33	Other(specify) Executive Director	1,904	2,168	31,658	14.60	33
34	TOTAL (lines 1 - 33)	233,433	252,999	$ 2,595,154 *	$ 10.26	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	221	$ 6,645	1-3	35
36	Medical Director				36
37	Medical Records Consultant	11	385	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	787	35,394	10a-3	40
41	Occupational Therapy Consultant	29	1,350	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	217	9,977	10a-3	43
44	Activity Consultant	20	984	11-3	44
45	Social Service Consultant	27	1,393	12-3	45
46	Other(specify)				46
47	Utilization Review Consultant	192	12,000	10-3	47
48					48
49	TOTAL (lines 35 - 48)	1,504	$ 68,128		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	11,286	200,446	10-3	52
53	TOTAL (lines 50 - 52)	11,286	$ 200,446		53

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Wesley Barber	Executive Director	00.0%	$ 31,658
Marilyn Hines	Administrator	00.0%	49,469
Administrative Assistants	Clerical	00.0%	26,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,127

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Scheffel & Company, P.C.	Accounting	$ 20,803
Greensfelder	Legal	7,101
McCarthy & Associates	Legal	4,716
Coffey & Gilbert	Legal	52
Lifelink, Inc.	Other	788
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 33,460

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 95,785
Unemployment Compensation Insurance	25,729
FICA Taxes	192,558
Employee Health Insurance	46,880
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	24,515
General Incentives	17,237
TOTAL (agree to Schedule V, line 22, col.8)	$ 402,704

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,504
Health Care Worker Background Check	
(Indicate # of checks performed 122)	
Marketing & Advertising	51,456
Dues & Subscriptions	10,204
Less: Public Relations Expense	(42,349)
Non-allowable advertising	( )
Yellow page advertising	(7,872)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 28,943

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
AFLA Convention, Florida (1/2 cost)	1,800
Missouri Seminar Travel	55
In-State Travel	
Seminar Expense	1,605
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,460

**See instructions.

Facility Name & ID Number Eden Village Care Center # 0023382 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Eden Village Care Center # 0023382 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. Life Services Network, $7,164

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 20

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 40,482 Line 10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 73,936
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? YES Indicate the amount. $ 4,866

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation. See pg. 21
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.